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MEDICAID MEMO

TO: Providers of Long-Term Care Services

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 9/2/2015

SUBJECT: Revised Patient Pay Payment Processing for Claims Submitted by Providers of Long-Term Services and Supports Except Those Providing Supports Under the Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFDDS) and Day Support (DS) Waivers — ***Effective October 1, 2015***

Effective for dates of service on or after October 1, 2015, most providers of long-term care services will not have to submit patient pay on claims. The Medicaid Management Information System (MMIS) will access the patient pay from the MMIS and automatically reduce the final claims payment by the amount of patient pay. This claims processing change does not affect the process for determining patient pay, how the patient pay will be calculated or the responsibility of the provider to collect patient pay.

Patient pay refers to the individual's obligation to pay towards the cost of long-term care services and supports if the individual's income exceeds certain thresholds. The patient pay amount is determined by the local departments of social services (LDSS). A patient pay determination is initiated when a provider of long-term care services and supports notifies the LDSS via the Medicaid LTC Communication form (DMAS-225) that an individual on Medicaid has been approved for long-term care services or supports or there has been a change in circumstances, income or assets.[1] The LDSS notifies the individual of the amount of monthly patient pay and enters this amount in the MMIS. The monthly patient pay amount is available to providers through multiple methods: the Automated Response System (ARS), the Virginia Medicaid Web Portal, Medicall and an electronic Health Care Eligibility Benefit Inquiry and Response transaction (270/271). This information is also available for Nursing Facilities and Intermediate Care Facilities for individuals with Intellectual Disability (ICF-ID) on the Eligibility Care Replacement Listing report (AS-O-317).

In the past, the provider responsible for collecting the patient pay has been listed on the individual's Notice of Obligation and the provider has been responsible for submitting the patient pay on the claim. The MMIS deducted the patient pay submitted on the claim from the final adjudicated payment amount. Claims with patient pay were subject to audit to verify the amounts submitted on the claim were correct.

Under the new system effective October 1, 2015, most long-term care providers should no longer submit the patient pay on the claim. The MMIS will automatically deduct the patient pay from the claim payment using the patient pay amounts directly reported to DMAS by the LDSS. Beginning in August 2015, the provider will no longer be listed on the member's Notice of Obligation. The MMIS will ignore the patient pay submitted on the

[1] Case managers and support coordinators are responsible for notifying the LDSS for individuals in the Intellectual Disability waiver or Individual and Family Developmental Disabilities Support waiver.

claim unless there is no patient pay in the MMIS. These MMIS claims processing changes affect all providers of nursing facility, ICF-ID (Intermediate Care Facilities for individuals with Intellectual Disability), hospice and PACE (Programs of All-Inclusive Care for the Elderly) services and providers of private duty nursing for members in the Technology Assisted Waiver, Adult Day Care for members in the EDCD (Elderly or Disabled with Consumer Direction) waiver and agency-directed personal or respite care for members in the EDCD waiver.

The only exception to application of these new rules is for those choosing to self-direct (consumer direct) their personal care services. When consumer-directed personal care services are authorized, the Fiscal Employer Agent, Public Partnerships LLC, will be responsible for deducting patient pay from any payments made for consumer-directed services. In this situation, patient pay will not be deducted from other claims paid through the MMIS.

Patient pay will be tracked monthly as claims are processed and will be deducted from each claim for long-term care services and supports included in the new patient pay processing on a first in (date of adjudication) first out basis until fully deducted. These claims will post edit EOB 1750 (Patient Pay Processing Logic Applied). Patient pay will not be dedicated to a specific provider. This means that patient pay may be deducted from multiple providers in a given month if there is a transition from one long-term care facility to another long-term care facility, from an HCBS waiver to a long-term care facility or from a long-term care facility to an HCBS waiver. Patient pay also may be deducted from multiple providers for members on HCBS waivers who receive multiple services included in patient pay processing in the month.

Providers must submit claims for all services, even if providers don't expect reimbursement for a claim due to patient pay. The only way that the MMIS can track patient pay is when a claim is submitted.

Providers are responsible for collecting only the amount of patient pay that is deducted from their claim. Providers can use the patient pay in the MMIS as the initial basis for requesting payment from members, but should be prepared to refund any excess amount collected to reconcile to the amount deducted from claims. This can happen when more than one provider of long-term care services and supports bills for services furnished in a month.

It is very important for long-term care providers to send in the Medicaid LTC Communication form (DMAS-225) on a timely basis so that the LDSS can update patient pay in the MMIS before new claims are processed. Providers should follow up with the LDSS if patient pay has not been updated in 30 days and escalate it to a supervisor if patient pay has not been updated in 45 days. Providers should contact the DMAS Provider HELPLINE if patient pay has not been updated in 60 days.

If patient pay is updated after claims are processed, those claims will not automatically be reprocessed. DMAS will receive a discrepancy report at the beginning of each month listing the paid claims associated with retroactive patient pay changes made during the prior month. DMAS will make manual adjustments for those claims using adjustment reason 1026 (Patient Payment Amount Changed). Depending on the volume, adjustments will be made within 30-60 days after receipt of the discrepancy report. Providers should contact the DMAS HELPLINE if an adjustment is not made within this time frame.

There will be no change in patient pay responsibilities for providers furnishing services to members in the Intellectual Disability waiver, the Individual and Family Developmental Disabilities Support waiver and the Day Support waiver. It is the responsibility of the case manager or support coordinator to assign a provider to

collect patient pay. The assigned provider should include the patient pay on the claim. DMAS may audit these claims for the correct patient pay amounts. When consumer-directed personal care is authorized, the case manager or support coordinator will defer to Public Partnerships LLC to deduct patient pay from any payments made for consumer-directed services.

While DMAS is also communicating these changes to individuals receiving long-term care services, long-term care providers are encouraged to discuss these changes with individuals they serve. Case managers and support coordinators for individuals with intellectual and developmental disabilities have specific responsibilities as part of their service to explain patient pay to individuals on Medicaid. Changes in patient pay collection should be addressed at the next meeting of the individual with the case manager or support coordinator.

Providers who have questions should call the HELPLINE. DMAS also has posted a patient pay fact sheet to its Long-Term Care web site at http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx. This fact sheet will be updated regularly in response to provider questions.

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a new program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx to learn more.

MANAGED CARE ORGANIZATIONS

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.